
Colorado Department of Health Care Policy and Financing

Presentation to the Joint Health &
Human Services Committees

January 28, 2010



HCPF Presenters

-
- Joan Henneberry, *Executive Director*
 - Dr Sandeep Wadhwa, *Chief Medical Officer and State Medicaid Director*
 - Sue Williamson, *Deputy Director, Client & Community Relations*
 - Phil Kalin, *Executive Director, CIVHC*
 - John Bartholomew, *Chief Financial Officer*
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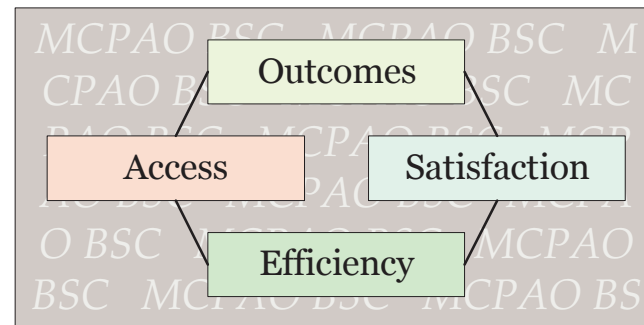
Department of Health Care Policy and Financing

- Federally designated agency to receive federal funds for Medicaid and CHP+
- Administers the following programs:
 - Medicaid
 - Child Health Plan *Plus* (CHP+)
 - Colorado Indigent Care Program
 - Old Age Pension State Medical Program
 - Comprehensive Primary and Preventive Care Grant Program
 - Primary Care Fund
 - Home and Community Based Services Medicaid Waivers

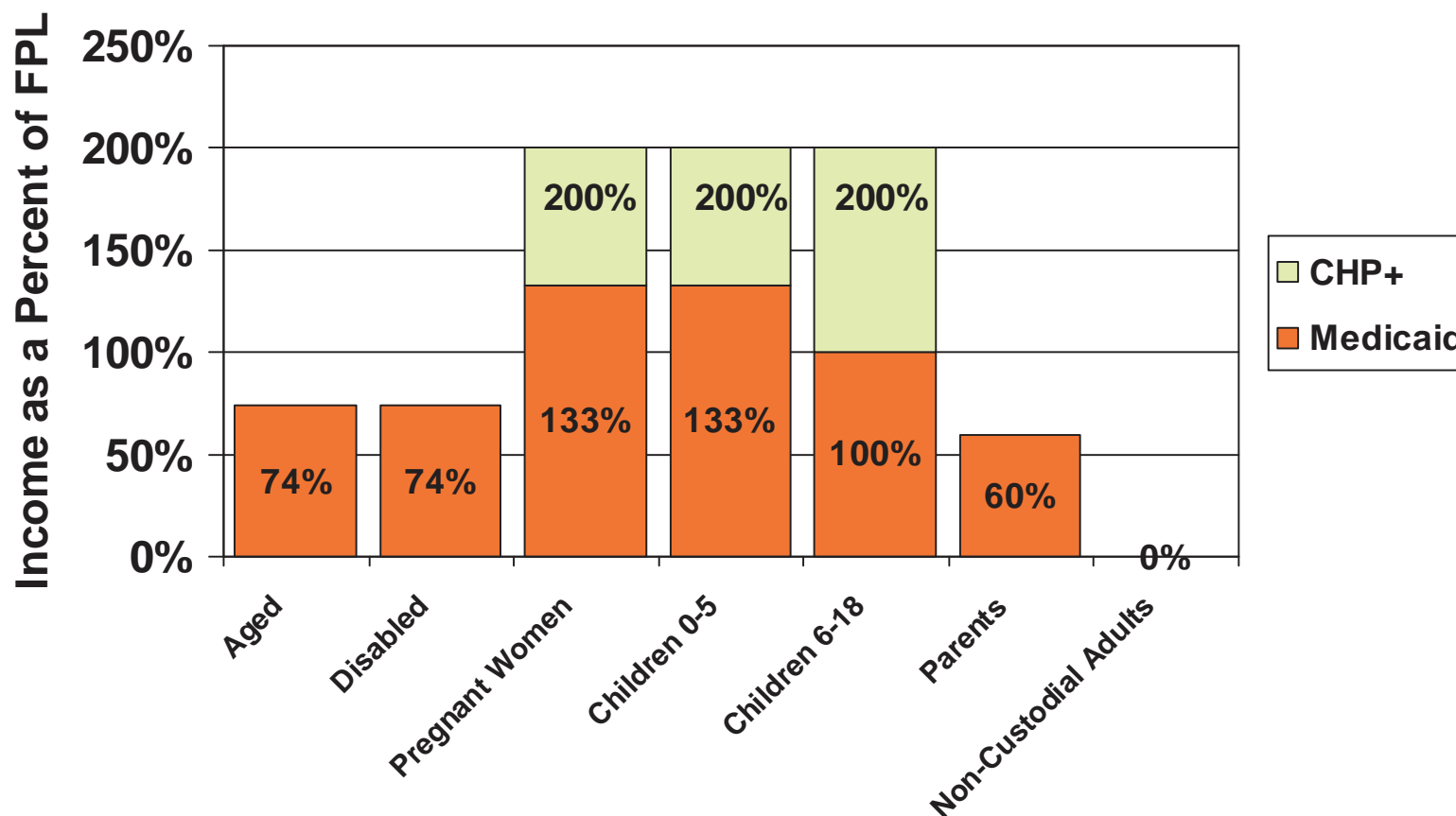


Internal Performance Improvement Initiatives

- Balanced scorecards for all offices with key performance metrics for outcomes, satisfaction, efficiency, access
- Internal audit function
- Contract management improvement
- Financial management system
- Project management tracking tool
- Risk management
- Legislative implementation status



Eligibility for Colorado Medicaid and CHP+



* For CHP+ a 2.5% income disregard is applied that equates to 205% of the FPL



Program Eligibility

Program	Income Eligibility	Other Requirements
Family Medicaid	Less than 60% - 133% FPL	Children age 0-18 and for parents with dependent children
Persons Who are Blind or Persons with Disabilities Who are Under Age 64	Blind or disabled Eligible for Supplemental Security Income (SSI)	Under the age of 64 and do not have dependant children
Persons 65 and Older	SSI and/or Old Age Pension (OAP) state supplemental payments Income limit is \$674	Age 65 or older Eligible for SSI and/or OAP state supplemental payments
Long-Term Care	Income limit is \$2,022 a month	Under age 65 must meet the Social Security disability criteria either through SSI eligibility or Social Security Disability Income (SSDI) eligibility Meet nursing facility level of care



Program Eligibility

Program	Income Eligibility	Other Requirements
Child Health Plan <i>Plus</i> (CHP+)	200% FPL and below	Low income children (18 years of age and younger) and pregnant women (19 years of age and older) Not eligible for Medicaid Do not have other health insurance
Breast and Cervical Cancer Program	Less than 250% FPL	Diagnosed through a Women's Wellness Connection site Between 40 and 64 years old No mammogram or Pap smear test in the last year No health insurance or it does not cover breast or cervical cancer treatment Not currently enrolled in Medicaid and are not eligible for Medicare
Colorado Indigent Care Program (CICP)	Less than 250% FPL	Cannot be eligible for Medicaid or CHP+ Must exhaust other insurance before CICP reimburses the health care provider



Medicaid Benefits

“Mandatory” Items and Services

- Physician services and medical/surgical services of a dentist
- Lab and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning
- Pregnancy related services
- Rural and Federally-Qualified Health Center (FQHC) services
- Nurse midwife services
- Nursing facility (NF) services for individuals 21 or over
- Certified Nurse Practitioner services
- Home health care services
- Transportation*

“Optional” Items and Services

- Prescription drugs
- Clinic Services
- Psychologist services
- Adult dental services
- Physical therapy and rehab services
- Prosthetic devices, eyeglasses
- Primary care case management
- Intermediate care facilities for the mentally retarded (ICF/MR)
- Personal care services**
- Hospice services

*Medicaid programs must provide assurance of transportation.

**Only covered as HCBS waiver service

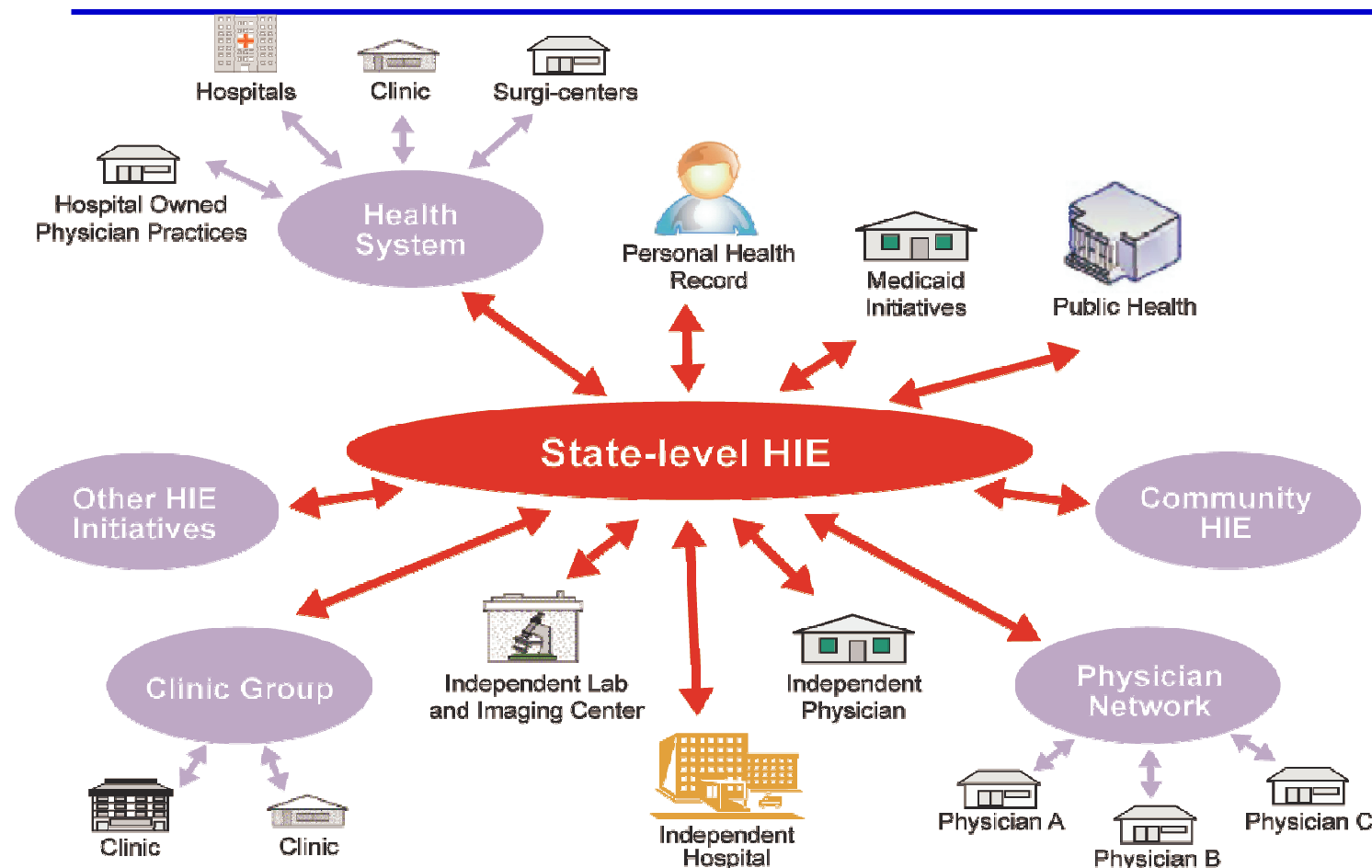


Colorado Medicaid Waiver Programs

- Children's HCBS
 - Children's Habilitation Residential Program (HCBS-CHRP)
 - Children's Extensive Support (HCBS-CES)
 - Children with Autism (HCBS-CWA)
 - Pediatric Hospice Waiver (HCBS-PHW)
 - Elderly, Blind, & Disabled (HCBS-EBD)
 - Supported Living Services (HCBS-SLS)
 - Persons with Developmental Disabilities (HCBS-DD)
 - Persons Living with AIDS (HCBS-PLWA)
 - Persons with Mental Illness (HCBS-MI)
 - Persons with Brain Injury (HCBS-BI)
-



CORHIO: State-level Convener/Coordinator and Solutions Provider/Broker (HIE Services)



Accomplishments

2007

- Established Preferred Drug List for Medicaid
- Launched Medical Home pilot program
- Expanded mental health benefits in the small group private market
- Invested in immunizations
- Launched anti-obesity & rural health initiatives with private sector partners

2008

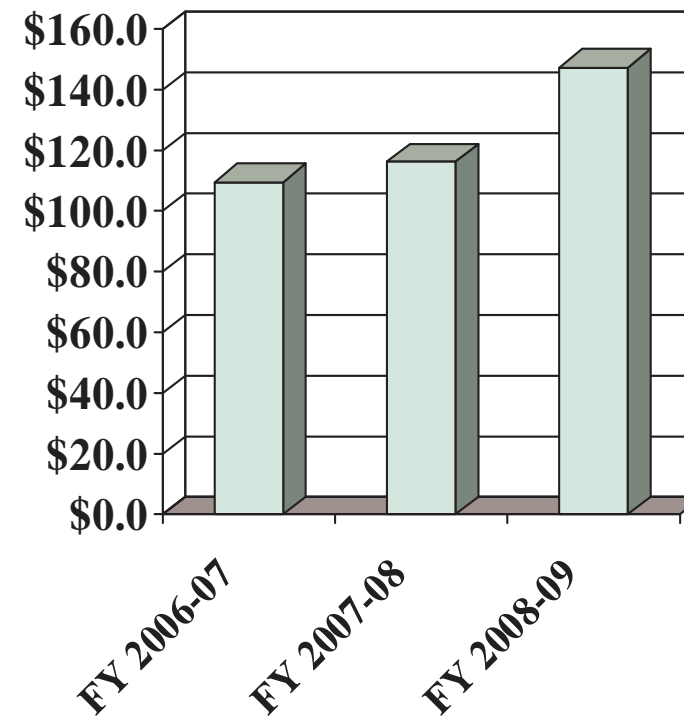
- Expanded CHP+ eligibility*
- Provided Medical Homes for all Medicaid & CHP+ kids
- Began Eligibility Modernization
- Increased Medicaid reimbursement rates*
- Established CIVHC
- Made Health IT investment through CORHIO
- Required standard health plan ID cards
- Established consumer resource website
- Launched CRICC program



Department Recoveries

- In the last three years, the Department has recovered over \$373 million in funds paid for fraud, waste, abuse and drug rebates.
- Governor Ritter's GEMS projects have greatly enhanced the Department's ability to identify these funds.

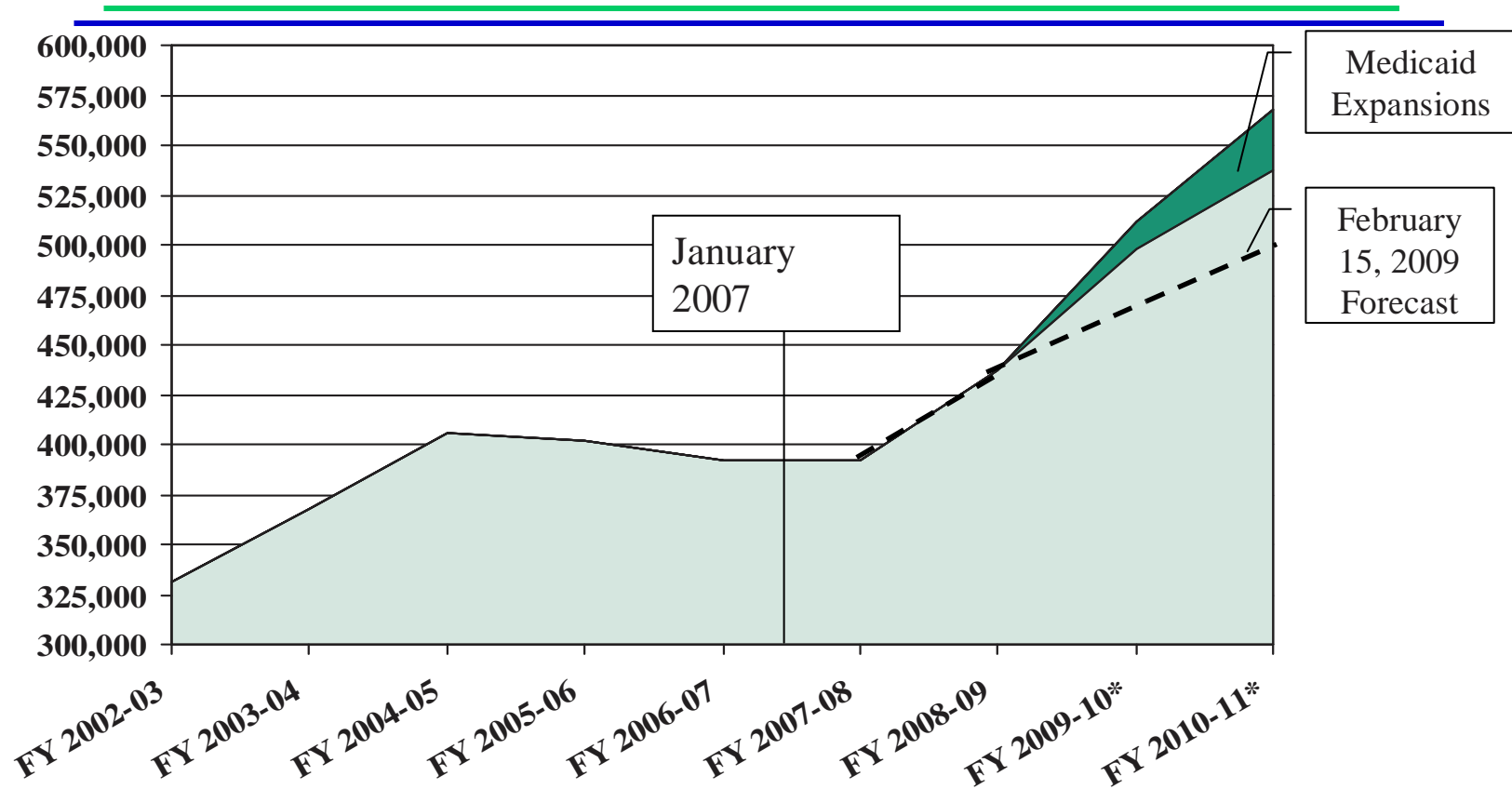
**Total Recoveries
(in Millions)**



John Bartholomew, Chief Financial Officer



Medicaid Caseload

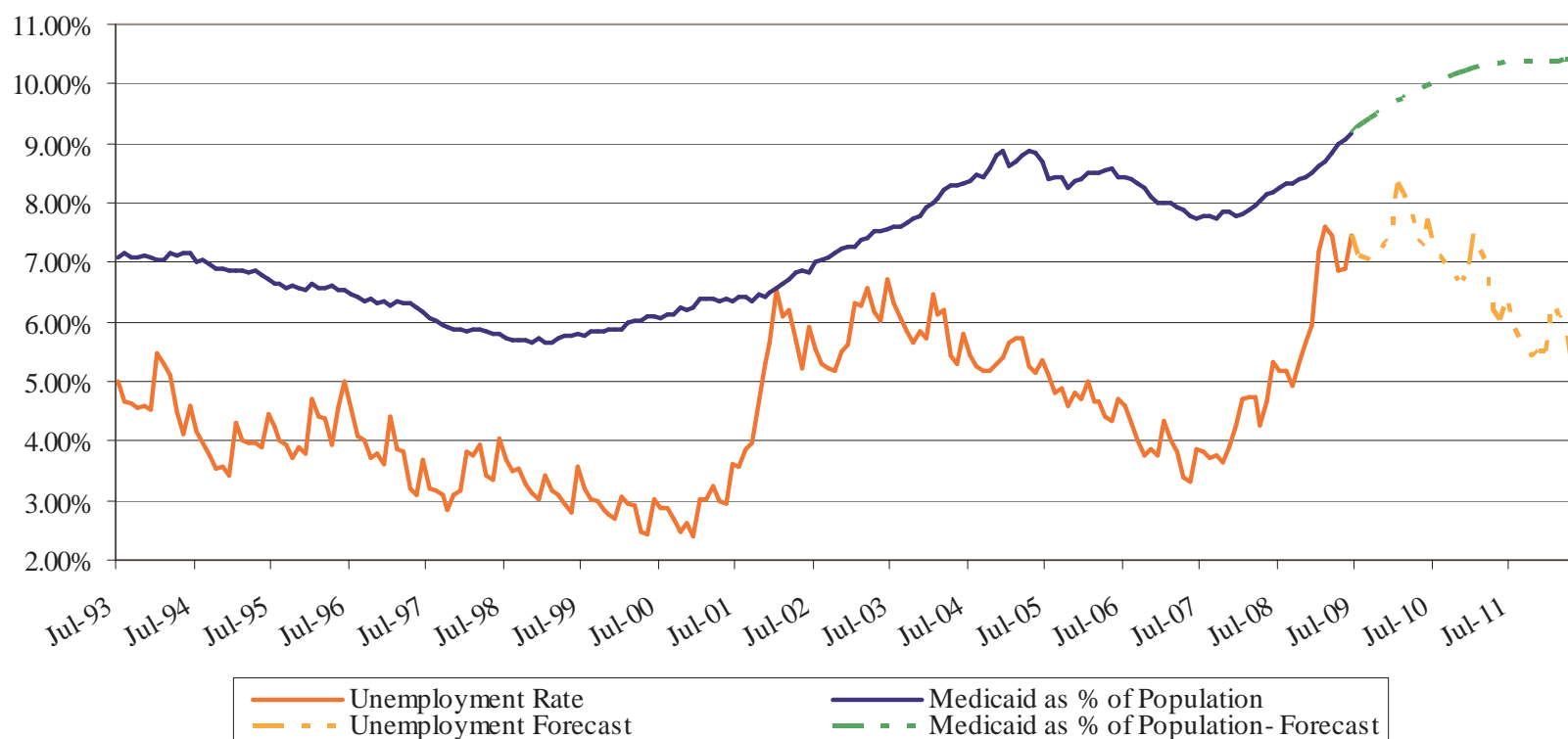


* FY 2009-10 and FY 2010-11 projections from the Department's November 6, 2009 Budget Request.

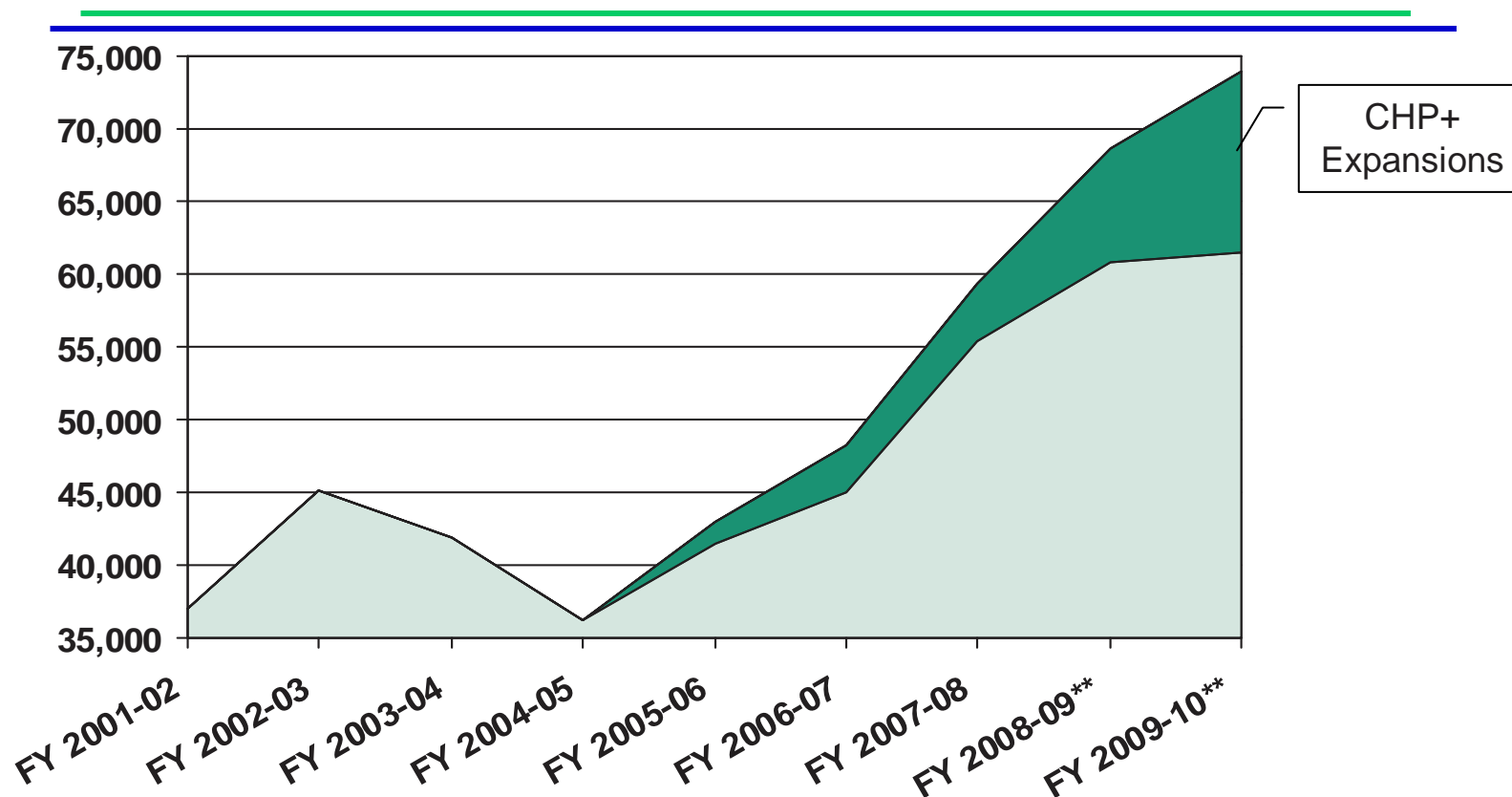


Medicaid Caseload

Colorado Medicaid Caseload v. Unemployment Rate



Child Health Plan *Plus** Caseload



* Includes children and prenatal.

** FY 2008-09 and FY 2009-10 projections from the Department's November 3, 2008 Budget Request.



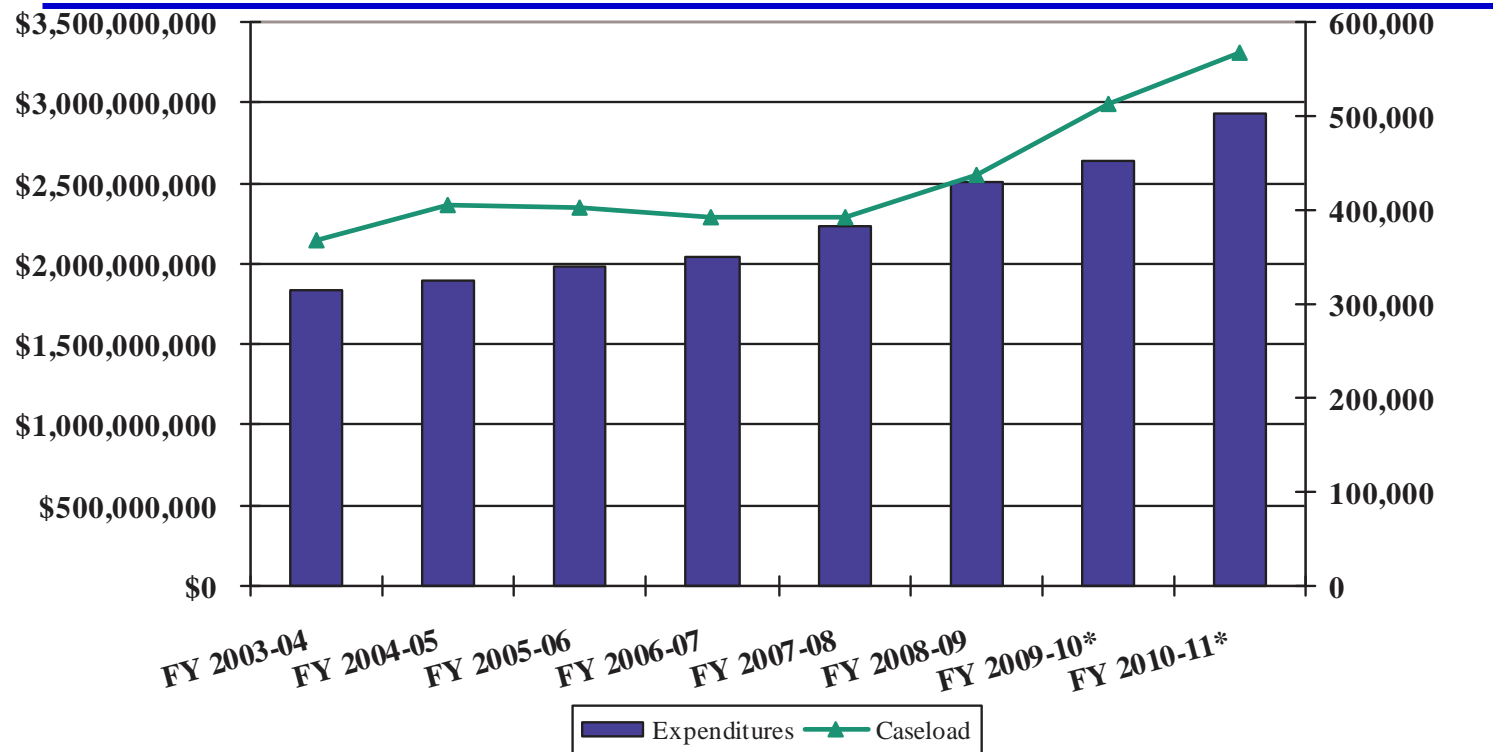
Current Medicaid Caseload

- Highest enrollment in history – 495,000
- 27% caseload growth
- 70,000 children and women in CHP+
- 45% caseload growth
- 40% served by safety net
- 70% - 90% physician participation
- 236,000 children in medical homes

Current as of December 2009



Medicaid Expenditures*



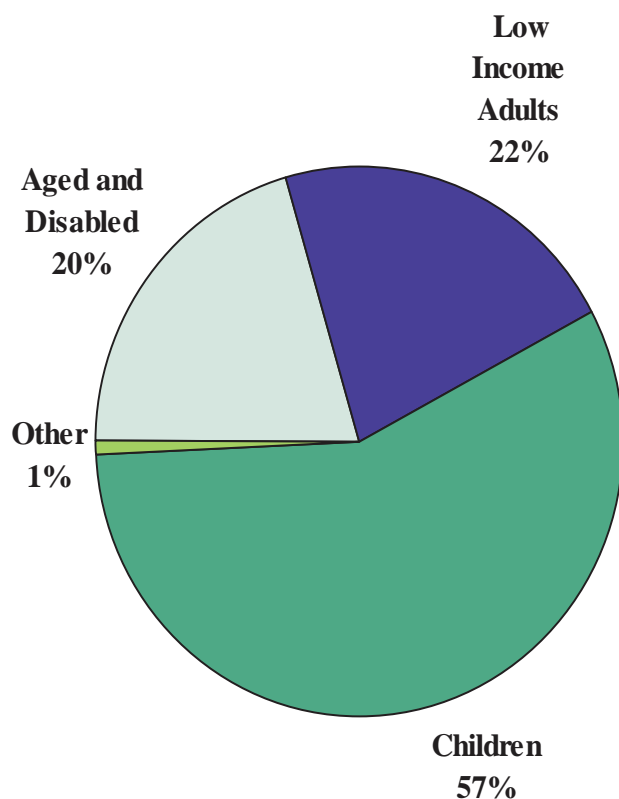
Medical Services Premiums	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10*	FY 2010-11*
Expenditure Growth	2.80%	4.71%	3.33%	8.72%	12.64%	4.82%	11.09%
Caseload Growth	10.48%	-0.95%	-2.48%	-0.07%	11.44%	17.08%	10.96%
Per Capita Growth	-6.95%	5.71%	5.96%	8.79%	1.07%	-10.03%	0.12%

* FY 2009-10 and FY 2010-11 projections from the Department's November 6, 2009 Budget Request.

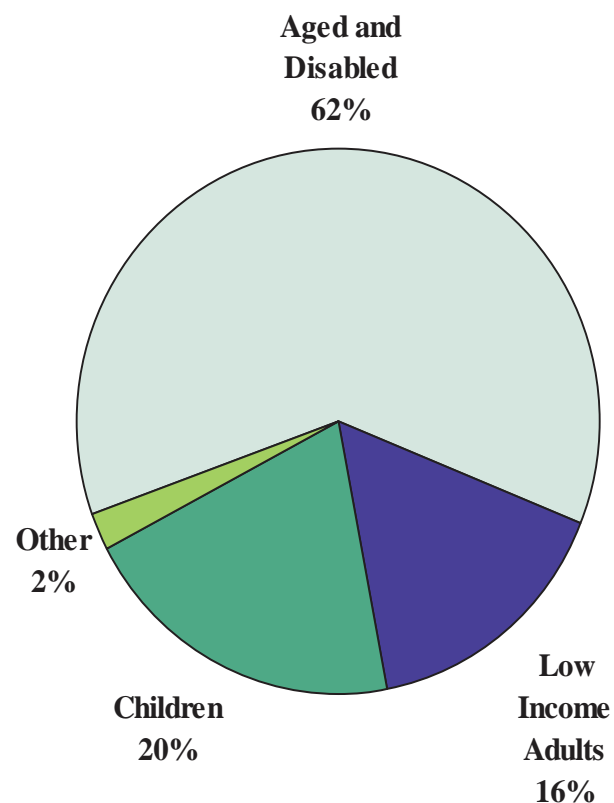


Projected Expenditure and Caseload Shares

FY 2010-11 Caseload



FY 2010-11 Expenditure



FY 2009-10 Budget Reductions

July, September, and December 2009

- Reduced \$299 million total funds, \$218 million General Fund from the FY 2009-10 Budget
 - Medicaid Provider Rate and Volume Reductions
 - Almost 4.5% in rates, plus additional utilization controls
 - Safety Net Reductions
 - Elimination of State-Only Grant Programs
 - Used ARRA/Enhanced FMAP to refinance General Fund where possible
 - MMIS Payment delays to prevent further rate/program reductions
- Limited the amount of federal funds lost to cuts



FY 2009-10 Budget Reductions

HCPF Reductions and Cuts (Totals in Millions)	Total Funds	State Funding
Provider Reductions		
Provider Rate Reductions and Program Efficiencies	(\$117.4)	(\$46.2)
Indigent Care Program Reductions	(\$41.6)	(\$31.6)
Administrative Reductions	(\$0.9)	(\$2.2)
Financing		
SB 09-264 ARRA/FMAP Reductions	\$0.0	(\$31.6)
Hospital Fee Financing from ARRA	\$0.0	(\$41.4)
Payment Delays		
SB 09-265 MMIS Delays	(\$94.7)	(\$43.7)
Additional Payment Delay	(\$44.8)	(\$21.2)
Total Reductions	(\$299.4)	(\$217.9)
ARRA -- Enhanced FMAP	\$0.0	(\$415.0)
Grand Total Savings	(\$299.4)	(\$632.9)



FY 2010-11 Proposed Budget Reductions

- \$194.4M Total Funds, \$329.4M State Funds
 - Payment Reform (COPPR) - \$2.5M TF, \$0.7M State Funds
 - Medicaid Efficiencies - \$10.1M TF, \$4.5M GF
 - Home Health unit billing change
 - Delay MMIS Payments - \$143.3M TF, \$72.6M State Funds
 - Medicaid Reductions - \$38.5M TF, \$28.3M State Funds
 - 1.0% Provider Rate Cuts - \$29.1M TF, \$12.0M State Funds
 - Restrictions to Optional DME - \$2.3M TF, \$1.2M State Funds
 - Nursing Facility Per Diem GF Cap Reduction - \$3M TF, \$13.7M GF
 - Reduce BHO Capitation Rates 2.0% - \$4.1M TF, \$1.6M State Funds
 - ARRA Enhanced FMAP - \$223.3M State Funds



Primary Care Participation in Medicaid

	10/08	03/09	11/09
Family Practice	70%	72%	75%
OB/GYN	80%	81%	84%
Pediatrics	87%	88%	89%
Internal Medicine	76%	78%	79%

Peregrine Management Corporation, 2009



Future Medicaid Growth

- Despite more than double the amount of cuts in the previous recession, Medicaid will continue to grow at a high rate in the future because of economic conditions and increasing health care costs.
 - In order to permanently control costs, there must be a strong focus on measures that maximize the value received for each dollar spent.
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Colorado Health Care Affordability Act

Riesberg, Ferrandino & Keller, Boyd

- Authorizes Department to assess and collect hospital provider fees
 - Creates a sustainable funding source
 - Increase Medicaid hospital rates and CICP payments
 - Reduce cost-shift to private payers
 - Quality incentive payments
 - Increase Expand Medicaid and CHP+ eligibility, expand health coverage to the uninsured
 - Pay Department's administrative costs
 - Creates Oversight and Advisory Board
-



Where Do the Funds Go?

Hospital Reimbursement

- Medicaid inpatient rates up to 100% of Medicare rates and Quality Incentive Payments
- Medicaid outpatient rates up to 100% of costs
- CICP rates up to 100% of costs

Upon CMS Approval in Spring 2010



Where Do the Funds Go?

Expansion of Public Health Care Programs

- Medicaid parents up to 100% FPL
 - CHP+ children up to 250% FPL
 - CHP+ prenatal up to 250% FPL
 - Disabled Buy-In up to 450% FPL
 - Adults without dependent children
up to 100% FPL
 - Continuous eligibility for
Medicaid children
- } Spring 2010
- } Summer 2011
- } Early 2012
- } Spring 2012



Reduction to Cost Shift

- The implementation of the hospital provider fee will reduce the need for hospital providers to shift uncompensated care costs to private payers, and ultimately employers, in the following ways:
 - Higher rates for public insurance clients.
 - Reducing the number of uninsured.
- Measurement of cost to payment ratio by payer
 - Report the difference between costs and payments for each of Medicare, Medicaid, and private insurance



Current Model

- Submitted to CMS in September 2009
- Questions received in December 2009
- Approval Expected in April 2010
- FY 2009-10 Model
 - Hospital Provider Fee Model is expected to generate \$210 million in new federal funds
 - Approximately \$87 million in new direct reimbursements for serving Medicaid and uninsured clients



Sue Williamson, Deputy Director Client and Community Relations



Colorado Eligibility Modernization Project

- Goals of Eligibility Modernization
 - Increase enrollment and retention (and access to services)
 - Implement a variety of self-service options that make it easier for applicants to apply for health care programs
 - Ease workload burden on eligibility workers and increase worker satisfaction
 - Reduce application processing times and provide good customer service
 - Increase administrative efficiencies
 - Reduce administrative costs
 - Leverage existing technology (eliminate reliance on paper)
 - Design and implement effective policies



Strands of Eligibility Modernization

- Systems (CBMS)
 - Phase I Colorado Program Eligibility and Application Kit (PEAK) (October 2009)
 - Phase II PEAK online application (April 2010)
 - Intelligent Data Entry – Fall 2010
 - Streamline Client Correspondence (ongoing)
 - Electronic interfaces with other state and federal databases
- Business Process
 - Eligibility and Enrollment for Medical Assistance Programs (EEMAP) RFP
 - Electronic Document Management System (scanning, imaging, OCR, document retrieval)
 - Interactive Voice Response
 - Workflow Management Process
 - Colorado Eligibility Process Improvement Collaborative (working with Medical Assistance sites to improve business processes)



HRSA State Health Access Program Grant

- Colorado Comprehensive Health Access Modernization Program (CO-CHAMP)
- “Champions” of policies that promote access to cost-effective, high quality health care services
- \$42.9 million over 5 years
- 7 discrete projects



CO-CHAMP Projects

- CHP+ at Work statewide expansion (premium assistance)
 - Health Access Program: Pueblo (3-share community)
 - San Luis Valley Health Access Program (3-share community)
 - Evidence-Based Benefit Design Pilot (private insurance market)
 - Maximizing Outreach, Retention and Enrollment (“Health Care Affordability Act” (HB 09-1293) expansion populations)
 - Eligibility Modernization (HB 09-1293 expansion populations)
 - Benefit and Program Design (HB 09-1293 adults without dependent children and buy-in for people with disabilities)
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Other Department Grants

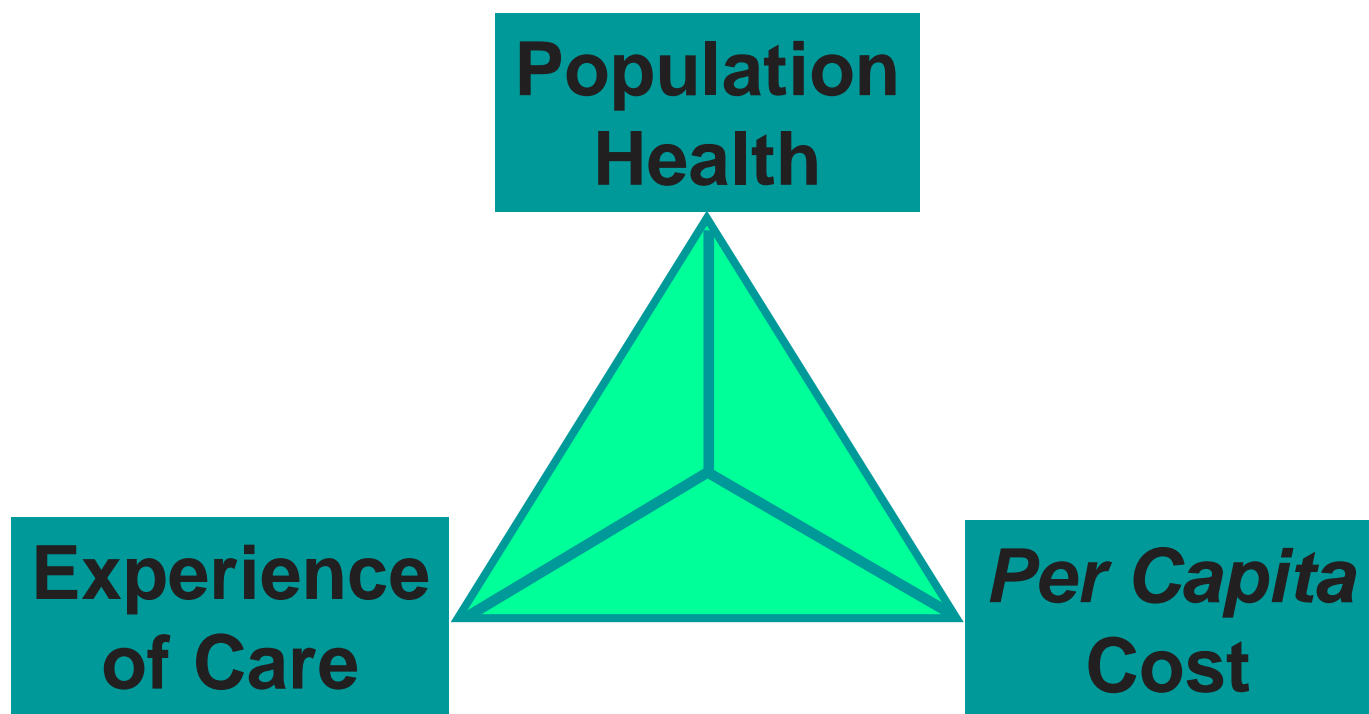
- July 2007 – December 2009
 - Grant Funding
 - \$51,390,805 awarded to Department
 - \$14,415,961 received to date
 - Grant Funded Activities
 - Colorado Household Survey
 - Community Outreach Projects
 - Eligibility Modernization
 - Emergency Room Diversion
 - CIVHC
 - Medical Home Pay for Performance Pilot
 - Technical Assistance
 - Recipient of five grants (health care reform initiatives, leadership, medical homes, state scorecard measures)



Phil Kalin, Executive Director, CIVHC



Consensus Around the Triple Aim



What's the Problem?

The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society on the other hand needs these three aims optimized simultaneously.

-Tom Nolan, PhD



Evolution of CIVHC

- From the Blue Ribbon Commission for Healthcare Reform (2008): “...creation of an inter-agency, multi-disciplinary group to facilitate and implement strategies to improve quality and contain costs.”
- From Governor Ritter’s Executive Order 005-08: “...develop a structured, well-coordinated approach to improving quality, containing costs, and protecting consumers in health care...”



Evolution of CIVHC (cont.)

CIVHC planning process included leaders from:

- Consumer groups
- Business groups
- Dept/Divisions of Public Health, Insurance, DPA
- Health care providers
- Health insurance carriers
- Health care organizations
- The Office of the Governor



Evolution of CIVHC (cont.)

Areas of research:

- Payment reform
- Data gathering, analysis, and distribution
- Consumer engagement and activation
- Health care delivery system improvements
- End of life care



The Result - CIVHC

The Center for Improving Value in Health Care (CIVHC) is a public/private coalition created to develop and implement statewide strategic initiatives that will improve the health of Coloradans, contain costs, and ensure better value for health care received.



Role of CIVHC

1. Establish Big and Audacious Goals/Objectives
 2. Serve as the statewide entity for promoting health, and facilitating and tracking high quality, cost-effective health care
 3. Identify gaps, barriers, successful practices and opportunities
 4. Set structure and actions to maximize multiple stakeholder involvement. Multi-pronged approach to issues
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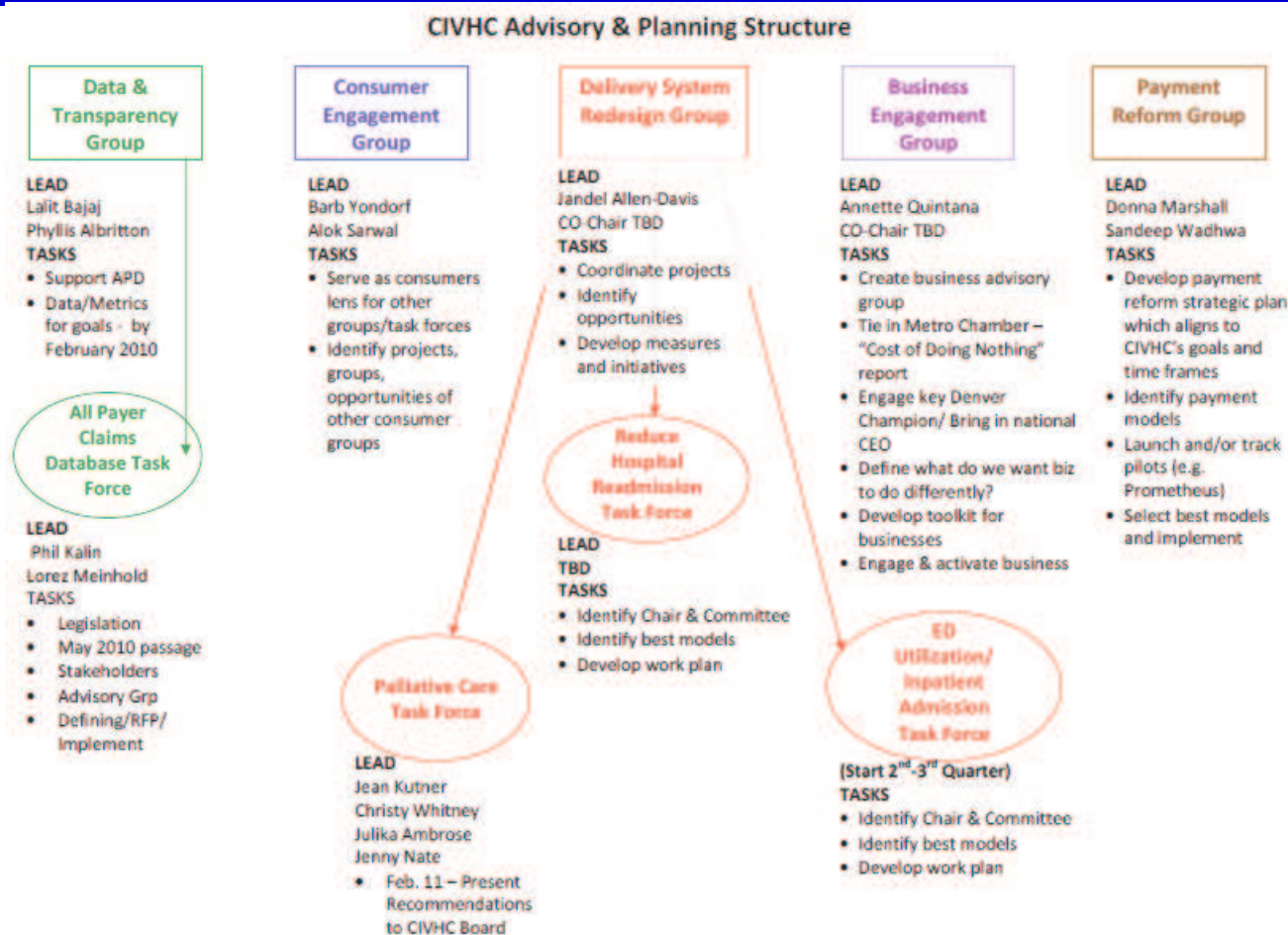
CIVHC

Long Term Goals (Draft)

Consumer-Centered Experience	Improved Population Health	Bending the Cost Curve	Increased Transparency
<p>By 2015, Colorado is in nation's top quartile in measures related to patient-centeredness including:</p> <ul style="list-style-type: none"> •Timely access •Communication •Participation in health decisions •Customer service 	<p>By 2015, Colorado is in nation's top quartile of measures related to:</p> <ul style="list-style-type: none"> •Access •Quality of services •Healthy behaviors and personal accountability 	<p>By 2015,: premium increases track at same rate as CPI (without shifting costs). Additionally:</p> <ul style="list-style-type: none"> •Reduce variability of cost across Colorado •Improve statewide ranking on cost 	<p>By 2014, cost, quality, and safety data for all providers is publicly available statewide.</p>
<p>Example of Measures: Consumer Assessment of Healthcare Providers and Systems (CAHPS)</p>	<p>Example of Measures: Commonwealth Fund, Colorado Health Report Card, HEDIS</p>	<p>Example of Measures:</p> <ul style="list-style-type: none"> •Measures of regional cost variability •Rankings nationally (e.g. Dartmouth Atlas) 	<p>Example of Measures:</p> <ul style="list-style-type: none"> •Regional cost variability •National rankings (e.g. Dartmouth Atlas)



CIVHC Advisory and Planning Structure

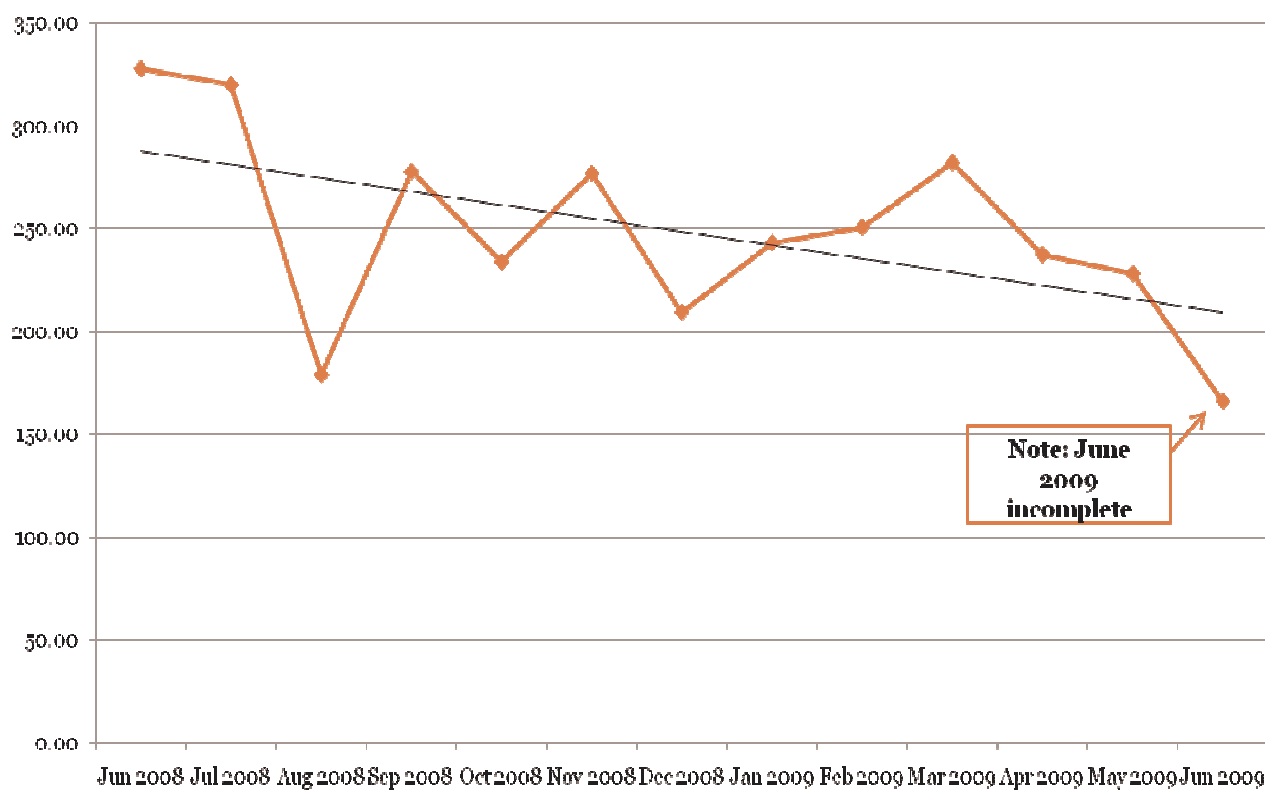


Dr Sandeep Wadhwa, Chief Medical
Officer and State Medicaid Director

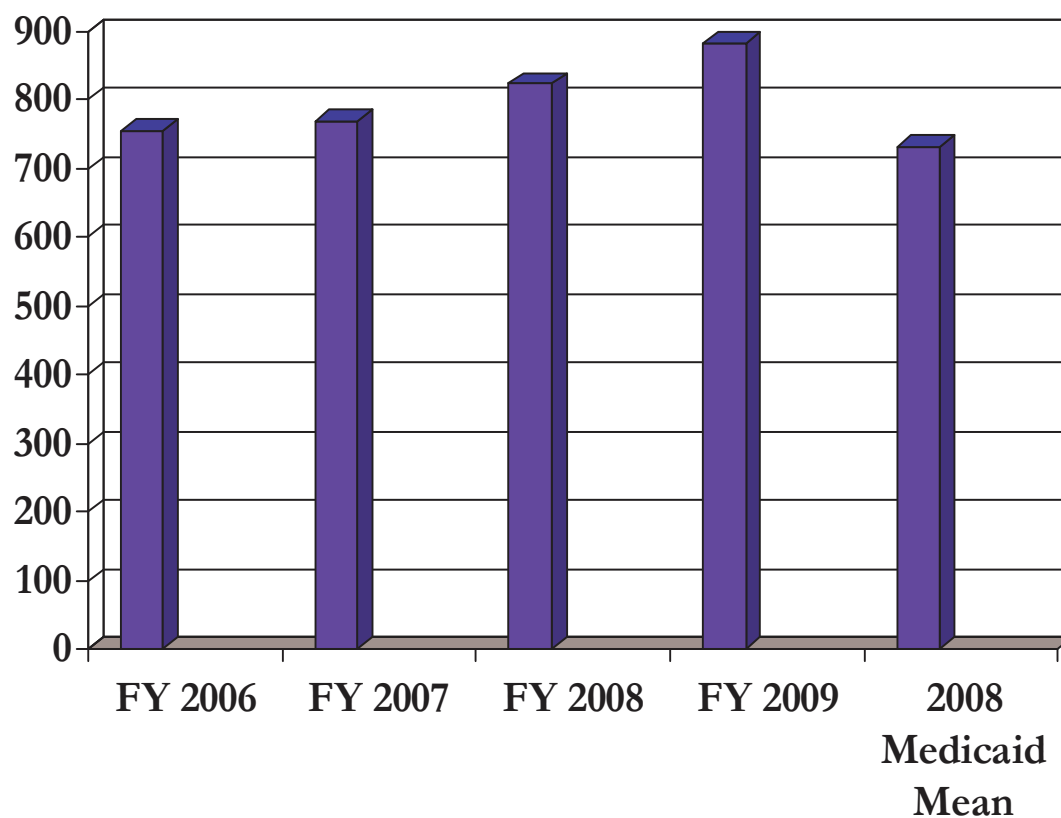


Colorado Regional Integrated Care Collaborative (CRICC)

Hospital Admissions per 1,000



Emergency Room Utilization Visits per 1000 FTE clients



Most Frequent ER Diagnoses by Age Group

<1 year

- Acute upper respiratory infection
- Fever
- Acute bronchiolitis
- Vomiting alone
- Otitis media

1-9 years

- Fever
- Acute upper respiratory infection
- Otitis Media
- Vomiting alone
- Croup

10-19 years

- Acute pharyngitis
- Abdominal pain
- Headache
- Ankle sprain
- Acute upper respiratory infection

20-44 years

- Abdominal pain
- Headache
- Migraine
- Chest pain
- Urinary tract infection



FY 08-09 ER visits per 1,000 FTE clients

50

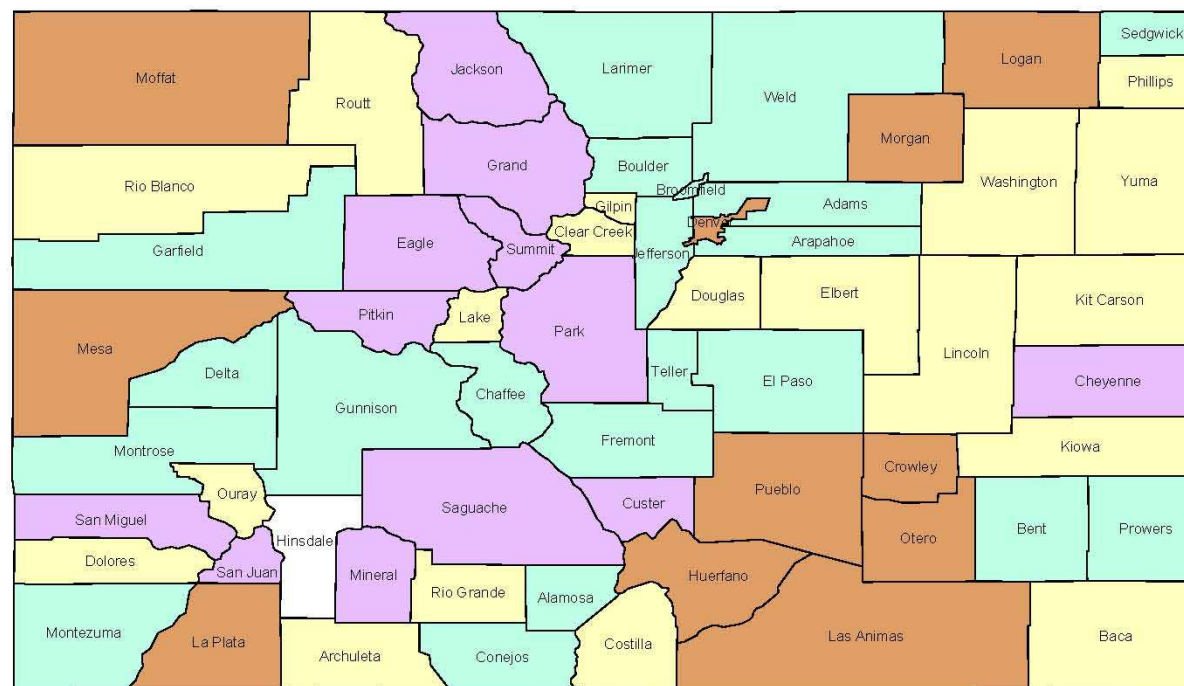
Range: 1,182 - 343

Median: 731

Legend

Colorado Counties

Category



ER Workgroup to Decrease Utilization

- Formed a multi-disciplinary team to advise on ways to decrease utilization
- Sent letters to high ER use clients encouraging them to use primary care providers and nurse advice line
- Adding nurse advice line prominently to eligibility card



Readmissions

- Rate of Hospital Readmission within 30 Days: 12.6%
- Over \$30 million per year
- The Department is working to identify those areas with the greatest potential to be significantly lowered.
- Successes:
 - Enforcement of 24-hour readmissions payment policy
 - BHO & Rocky Mtn. Health Plan: Contracts contain performance standards for readmission rates.
 - Stakeholder committee working to establish hospital performance payments has consensus on incentive payments for readmission rate reduction.
 - Dr. Judy Zerzan is co-chairing a national workgroup of state Medicaid agencies working on lowering rates of readmission.



Department Progress

FY 2009-10 Medicaid Program Efficiencies

- Serious Reportable Events
 - Implemented October 1, 2009
 - Improvement in quality expected
 - All CO hospitals cooperating with program
 - Fluoride Varnish
 - Implemented July 1, 2009
 - Treated 14,300 children
 - Benefit Collaborative
 - Women's health services, pediatric dental, echocardiogram, therapies (speech, OT, PT)
-



Department Progress

- Provider Volumes and Rate Reductions
 - Updated provider codes to below 100% of Medicare rate after Medicare rate reductions
- Enroll eligible Veterans in VA health care system
 - Identified 3,100 potential clients
 - Working with VA outreach



Colorado Accomplishments in Long Term Care

- Enactment of HB 09-1103, *Riesberg and Newell* authorizing the pursuit of presumptive eligibility for long term care clients.
 - Working with CMS on implementation options
- Initiated a work group with Colorado Division of Housing, Colorado Housing Finance Authority, and advocates to address housing issues for LTC eligible clients.
 - identify and solve barriers in accessing housing
 - expand housing options



Colorado Accomplishments in Long Term Care

- Executive Order Directing Development of Olmstead Plan signed in June 2009
 - Workgroup to deliver plan to build community capacity and promote health, functioning and self-sufficiency by July 1, 2010.
- Expand Care Transition Services to clients in MI waiver in FY2009-10

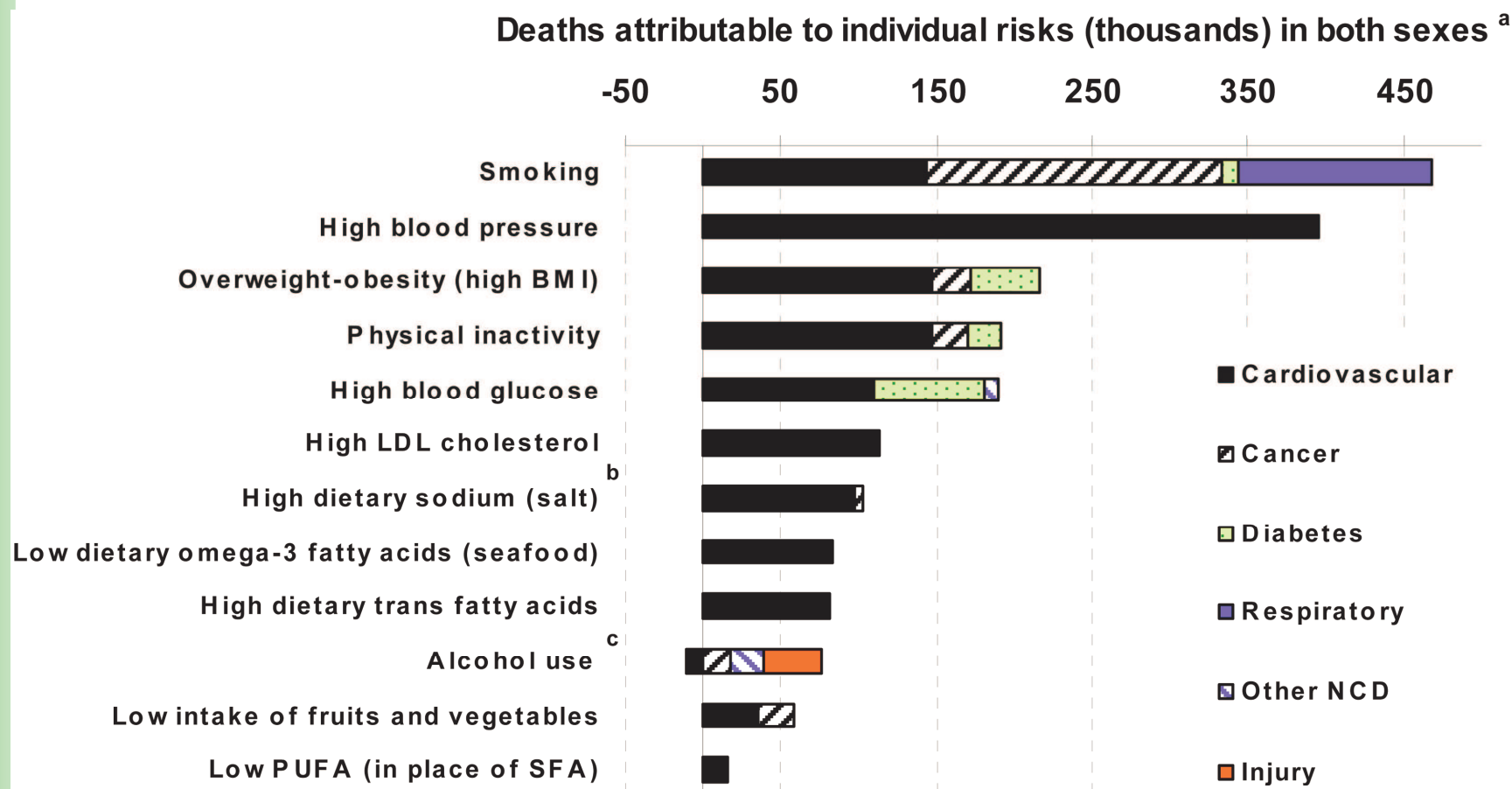


Maximizing Value

- Maximize health, functioning and self-sufficiency of all clients
- Optimize efficiency in the expenditure of taxpayers' money
- Balance these goals by maximizing value in Medicaid



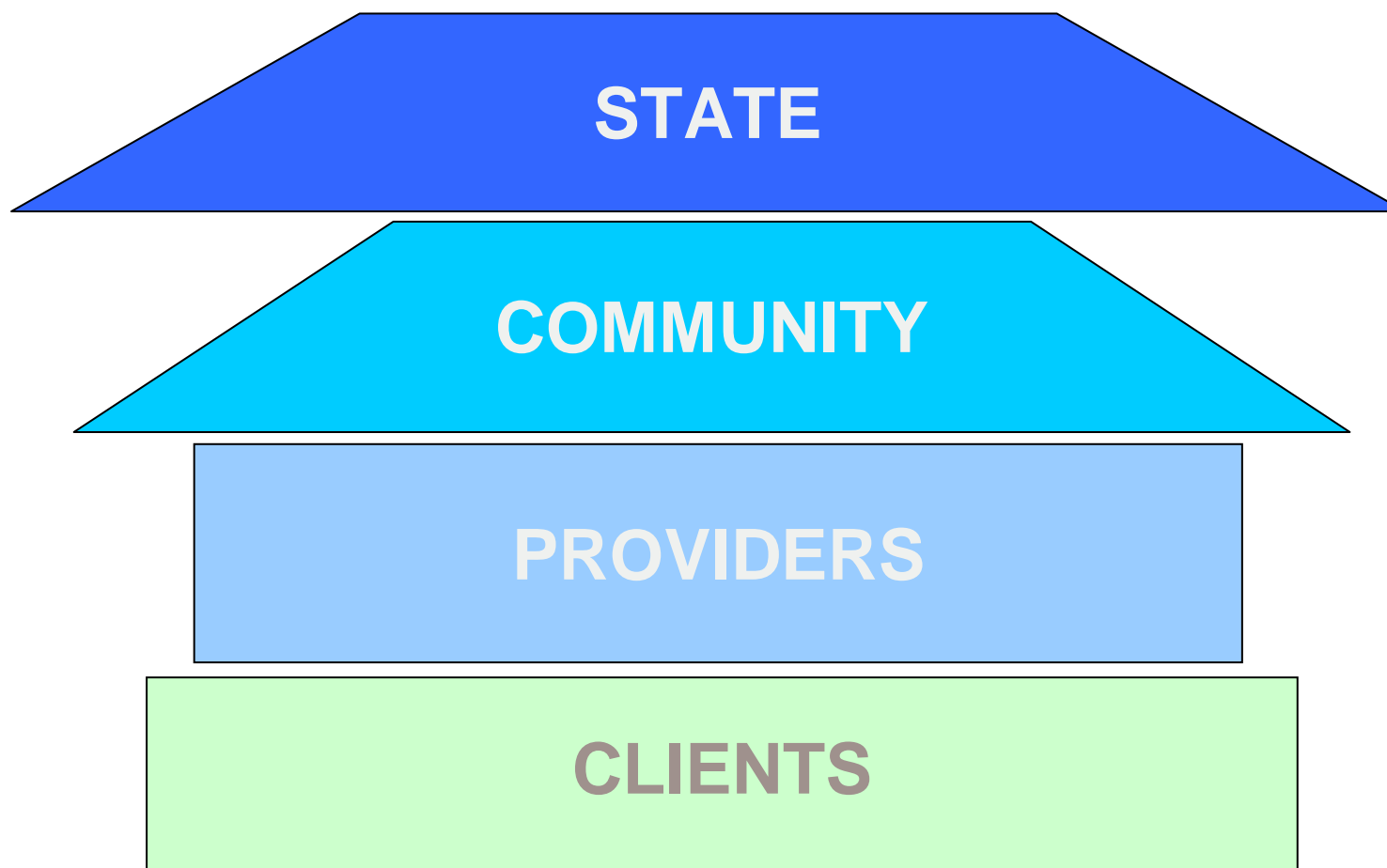
Preventable Causes of Death



Danaei, The Preventable Causes of Death in the United States ..., PLoS Med 6(4), 2009.



Initiatives Occur At Varying Levels



Utilization Review Reform

- Department's UR systems are outdated
- Proven and rapid means of safely controlling medical spend
 - UR = 3.5 ROI *
 - New radiology review yielding 11% reduction in claims
 - Next hospital outpatient, outliers, specialty, additional therapies
- An increase of \$118,359 total funds, with a reduction of \$11,201 General Fund in FY 2010-11

* The Society of Actuaries: 2004

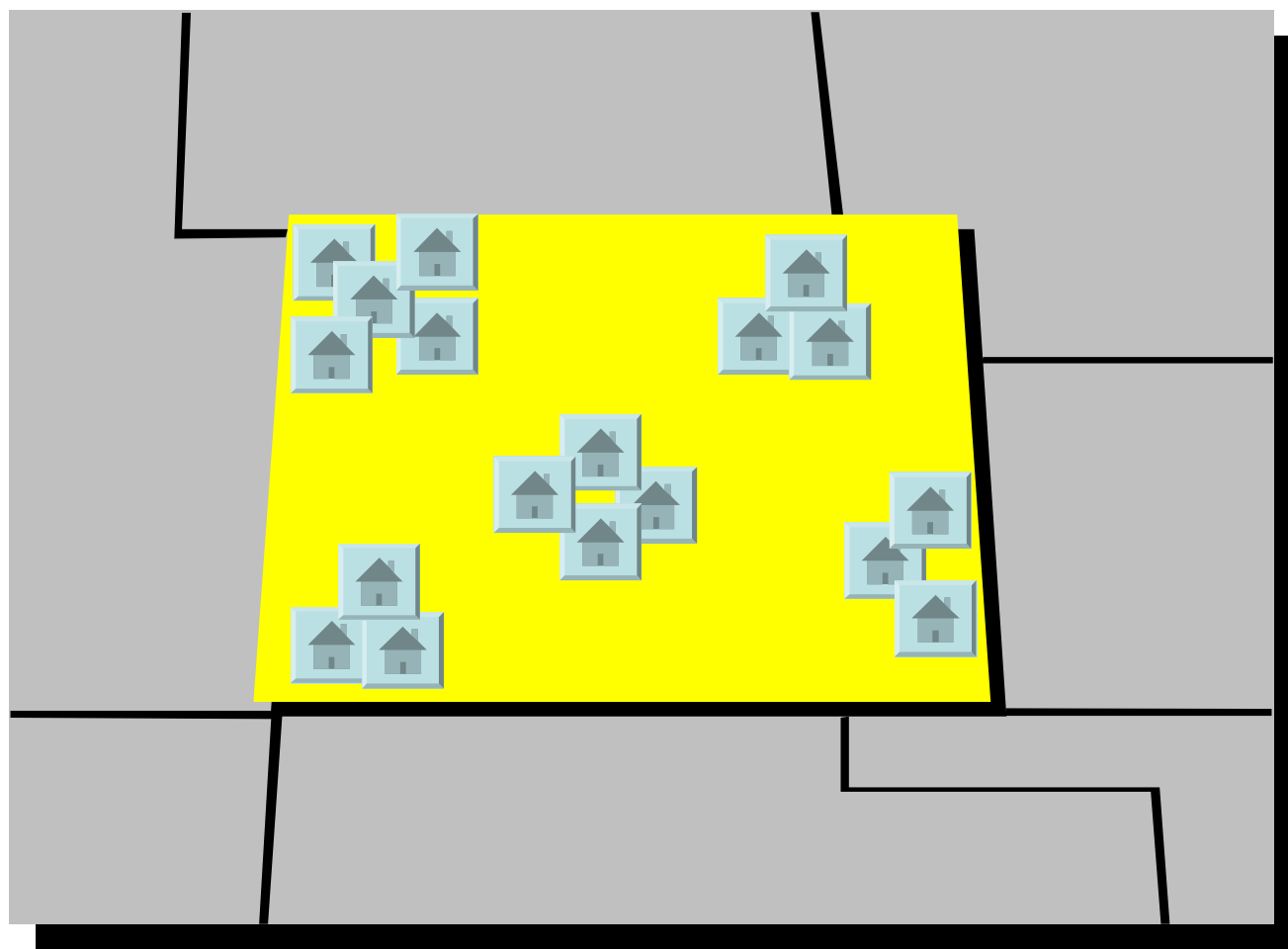


Evidence Guided Utilization Review (EGUR) Strategy

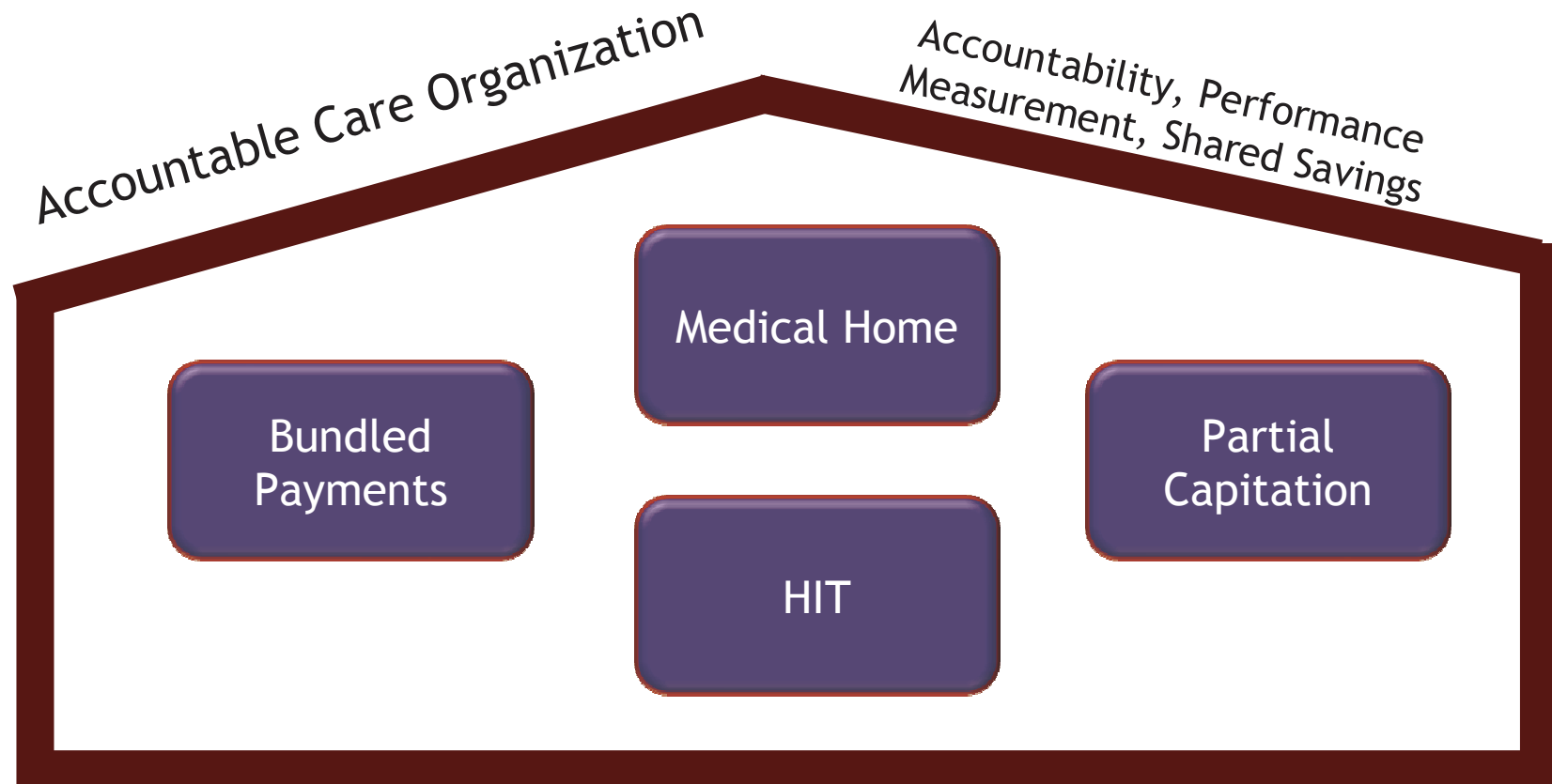
- Re-procurement of QIO July 1, 2010, including vendor consolidation
 - Implementation of systems and technologies that:
 - Lower Department costs for manual reviews
 - Lower provider administrative burden
 - Build evidence-based standards into work flows
 - Stepwise approach with other initiatives
 - Pharmacy auto-PA as platform for additional PAR systems
 - Coordinated provider Web portal
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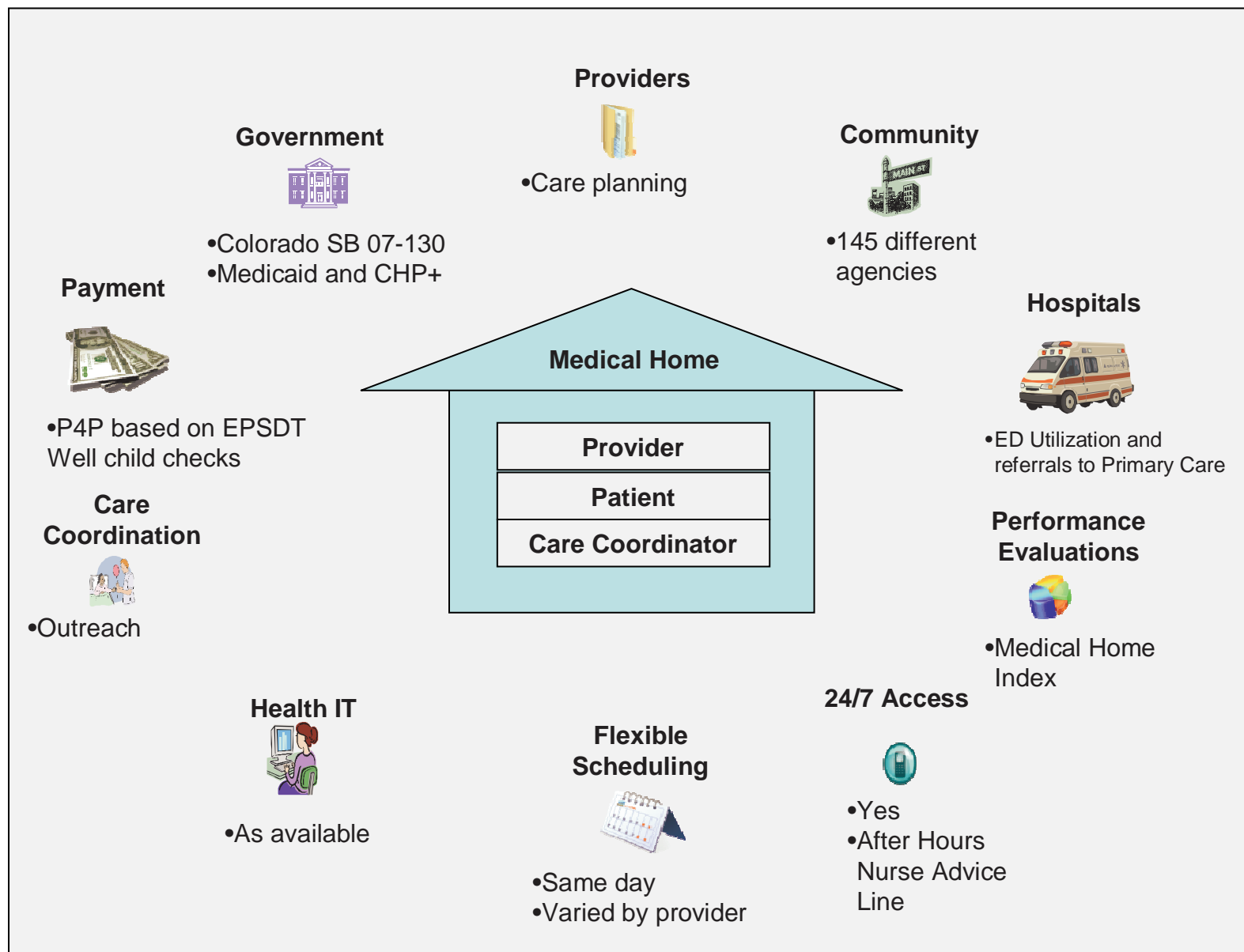


Health Neighborhoods



The ACO is the overarching structure within which other reforms can thrive





Department Progress

Accountable Care Collaborative

- Client
 - Establish a usual source of primary care for all Medicaid clients
 - Coordination across care settings, including social services
 - Emphasis on promoting health and functioning
 - Providers
 - Financial support for caring for complex clients
 - Social and care management support for clients
 - Share in cost-savings
 - State Benefits
 - Outcomes driven – reduce costs and improve population health
 - Allow regional entities to organize health neighborhoods
 - Regional pilots to benchmark success
-



How does ACC reduce expenditures?

Through systematic efforts to improve outcomes and reduce costs across the community:

- Using appropriate workforce
- Improved care coordination
- Reduced waste (i.e. duplicate testing)
- Internal process improvement
- Informed patient choices
- Chronic disease management
- Point of care reminders and best practices
- Actionable, timely data
- Choices about capacity



Department Progress Accountable Care Collaborative

- Current Status
 - Initial outreach completed
 - RFI responses analyzed
 - Drafting RFP
- Timeline
 - 5-7 pilot programs sequentially, launching November 2010
 - Enrollment goal = 60,000
 - 40,000 adults & 20,000 children

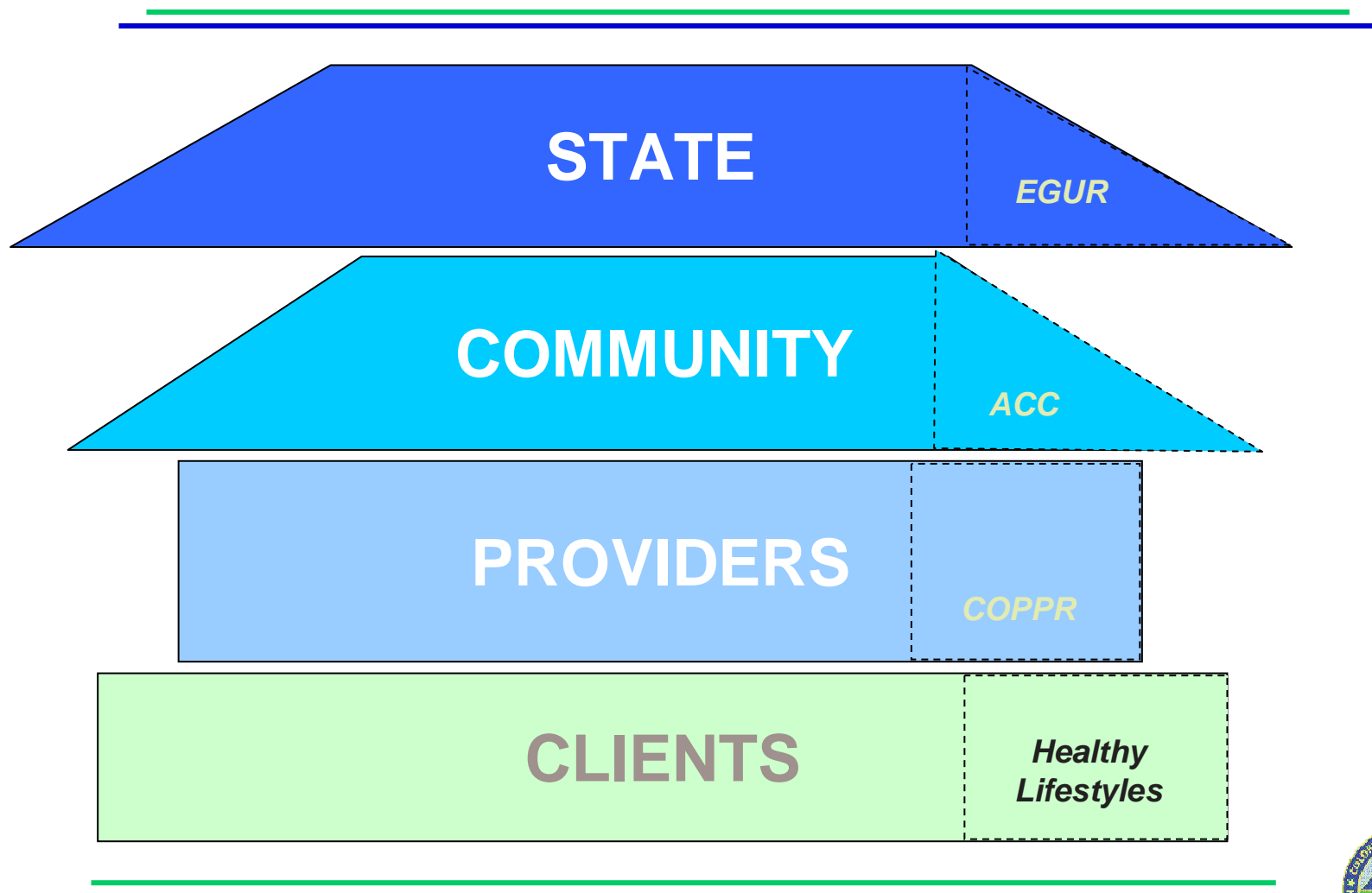


Coordinated Payment and Payment Reform (COPPR)

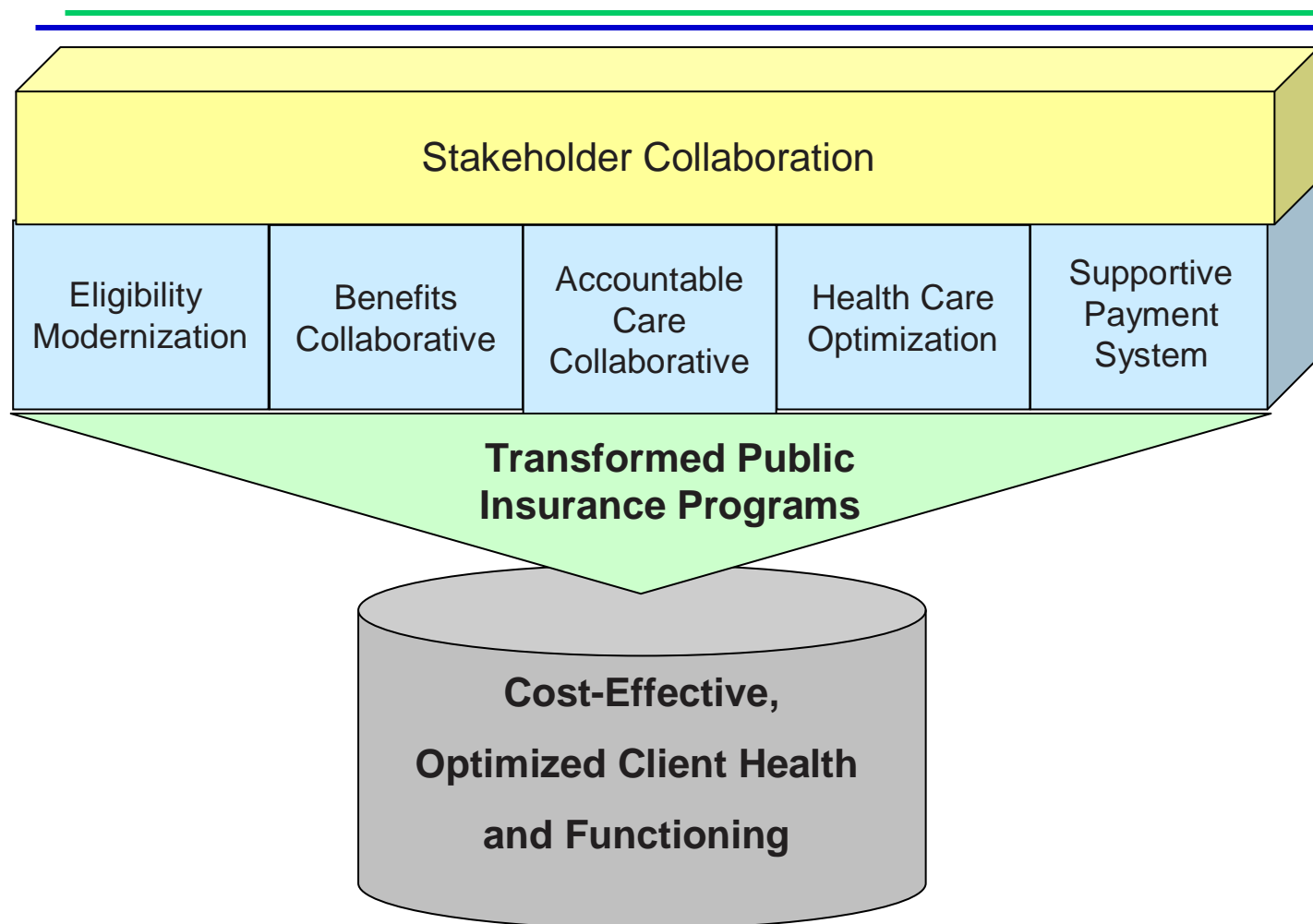
- Two main features to COPPR:
 - Investment in Payment Reform
 - The Department intends to develop payment methodologies which reward outcomes, instead of just billing
 - Waiver services, physicians
 - Savings from Coordinated Billing and Payments
 - Ensuring clients who are eligible for Medicare get enrolled in Medicare
 - Ensuring that the right providers pay for the right services
 - Systematic, sequential effort to move away from Fee For Service pricing
 - Estimated savings of \$2.5 million total funds, \$500,000 General Fund in FY 2010-11
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Interventions



Reform Vision



Joan Henneberry, Executive Director



Connecting the Dots

- Household Survey
 - CORHIO
 - Eligibility Modernization
 - Efficiencies and cost-containment
 - Provider recruitment and retention
 - Better care management
 - CIVHC and Payment Reform
 - Cost-effective, Optimized Client Health and Functioning
-



Future Initiatives

- Medicaid Efficiencies Act
- All Payer Claims Data Base
- Preparation for National Reform
 - Analyze and score impact for CO
 - Insurance Regulations
 - Medicaid Expansions
 - Designing an Exchange
 - Pilot Programs
 - Service delivery & payment reform



“Colorado is one of the states best positioned to move forward with health care delivery system reforms and coverage expansion necessary to both increase access to care and help bend the cost curve.”

-Len Nichols

*Len Nichols, PhD, directs the health policy program at the non-partisan
New America Foundation*



For more information
please visit our Web site:

colorado.gov/hcpf

